JOINT STANDING COMMITTEE ON THE COMMISSIONER FOR CHILDREN AND YOUNG PEOPLE

REVIEW OF THE FUNCTIONS EXERCISED BY THE COMMISSIONER

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
MONDAY, 10 AUGUST 2015

SESSION ONE

Members

Ms L.L. Baker (Chair)
Hon Robyn McSweeney (Deputy Chair)
Ms E. Evangel
Hon Sally Talbot

Hearing commenced at 9.37 am

Professor FRANK DALY
Acting Chief Executive, Child and Adolescent Health Service, examined:

Ms LISA BRENNAN
Acting Executive Director, Child and Adolescent Community Health Service, examined:

The CHAIR: Thank you both for coming. You have been to committees before, so you understand how this works?

Prof. Daly: Yes.

The CHAIR: I will read the opening statement. On behalf of the Joint Standing Committee on the Commissioner for Children and Young People, I would like to thank you for your appearance before us today. The purpose of this hearing is to assist the committee in its review of the functions exercised by the Commissioner for Children and Young People, with particular reference to the recommendations contained in the recent—we probably should change that to "not quite so recent"—review of the Commissioner for Children and Young People Act. At this stage I will introduce myself, Lisa Baker, the member for Maylands, Chair of the committee; Hon Robyn McSweeney, member for South West Region, Deputy Chair; and Hon Sally Talbot, the member for South West Region as well. We like the south west here! This hearing is a formal proceeding of the Parliament and therefore commands the same respect given to proceedings in the house. Even though the committee is not asking you as witnesses to provide evidence on oath or affirmation, it is important that you understand that deliberate misleading of the committee is contempt of Parliament. This is a public hearing and Hansard is making a transcript of the proceedings for the public record, so any documents you refer to, it would help if you could provide the full title for the record.

I have just a few very quick questions. Have you completed the "Details of Witness" form?

The Witnesses: Yes.

The CHAIR: Do you understand the notes at the bottom about giving evidence to the committee?

The Witnesses: Yes.

The CHAIR: Did you receive and read the information for witnesses sheet provided with the "Details of Witness" form today?

The Witnesses: Yes.

The CHAIR: Do you have any questions in relation to being a witness today?

Prof. Daly: No; thank you.

The CHAIR: Thank you both for coming, first of all. We are involved in the review, as you have heard, and this piece of research that we are conducting is into particularly what role should the commissioner be looking at in relation to the reporting of child abuse and the whole spectrum around child abuse. It is proving to be quite an interesting question. What went from, I suppose, originally, Justice Blaxell's fairly clear description of a one-stop shop—he has since elaborated on what he was talking about when he said that. He said to this committee in evidence not so long ago that he was particularly focusing on the journey that a child has through the process of reporting, which is, by its very nature, a fraught one, and that there is seldom a friend of the child available around and throughout that whole process—one person that they can relate to. So, he was very insightful in putting that on the table for us to consider. There are of course other things we are

interested in about the role of the commissioner, so we have looked at eastern states and international models about the way they are working on this issue as well. I suppose our reason for bringing you guys here is that you have a very important role in this process, in our view. I will start the ball rolling; my colleagues have some questions as well that they will want to follow on with.

We noted that you regularly participate in training events with WAPOL's child abuse squad and the Department for Child Protection and Family Support to ensure that a child or young person's health needs during any investigative process are not overlooked. So for the benefit of our committee, could either Frank, you, or Lisa—is informal naming okay?

Prof. Daly: I much prefer being called Frank.

The CHAIR: Ditto, except not Frank; you can call me Lisa!

For the benefit of the committee, could you please explain the current arrangements between Health, WAPOL, child protection, which come into play when a case of abuse is encountered? Is that clear?

Prof. Daly: Yes. Lisa would you like to comment?

Ms Brennan: Sure. Perhaps if I start off with what our role is as an agency.

The CHAIR: I should say if you want to make an opening statement, by all means feel free.

Ms Brennan: We have two key roles, and the statewide protection for children in care unit sits within the community health service. The function of that particular service is really to provide the overarching training for mandatory reporting, particularly to doctors and nurses, who are mandatory reporters, but also to other healthcare professionals. They also provide the training to the Department for Child Protection and Family Support with regard to what the health assessment and medical needs often are of the child during that investigatory process, so that is a statewide function. They provide that training to the metropolitan area as well as to the country regional areas. They also provide health assessments for children who are already in care who may have already had an identified sexual abuse case and have been taken away from the family. The other component of the service that we provide is the child protection unit, which is based at Princess Margaret Hospital, and they deal specifically with, quite often children who may come through the hospital, but they also may be referred from elsewhere, and they do the health investigation for potential sexual abuse mostly, although it can be any form of abuse. They are probably the two different functions that our agency provides.

Coming back to your question, the referral process for a suspected case is normally through the department of child protection and also WA Police. Our role is to do the health assessment of the child and make sure that the medical needs of the child are considered, and that includes the psychosocial components as well as the physical health components.

Do you want to read me your question back again and I will make sure that I have —

The CHAIR: Do you want to explain in a bit of detail about how those arrangements work between you and WAPOL and child protection; how you carry out one of those functions, anyway—or probably both of those functions? Can you just walk the committee through how you do it?

Ms Brennan: How we do it. Okay, so with regard to the training component of mandatory reporting, we provide as a statewide function all the training across the agencies. That is multidisciplinary, multi-agency training, so we have members from the other agencies who obviously contribute to the training program. Last year we delivered 104 training sessions, and the health participants were 1 298. The non-health participants were 1 061.

The CHAIR: Is there an accreditation? Is it an accredited training program that you offer or is it an in-house developed course?

Ms Brennan: It aligns to the legislation that was brought in several years ago. We provide face-to-face training, but there is also an e-learning module which health professionals and mandatory reporters have to complete as part of their induction process into the service. That also complies with the legislation as well.

The CHAIR: In the training that you deliver to people who are involved in mandatory reporting, is there training around what happens after you—so, I have made a call to the mandatory reporting line and stated my concerns and gone through the process, what happens after I have hung up that phone? As an individual who has reported, what do I then find out or what is the information that I get after I put down the phone?

Ms Brennan: That is a good question. It is probably one of the concerns that has been raised. From a health perspective, I guess we have two processes. For doctors and nurses, if they suspect that a child is being abused, then they will make the call themselves. If they have a good relationship with DCP or WA Police, they will often get some feedback in terms of the investigatory process. Sometimes we do not get anything back—I will put that on the table. If it is an allied health professional, for example, who is not a mandatory reporter, so it could be a social worker or a physiotherapist, somebody like that, they will refer the case to perhaps a doctor who is a mandatory reporter who then reports into DCPFS or to WA Police. What that person gets back at the end of the communication process may be very little or it may be nothing at all. I guess part of that is partly to protect the child and the family during the process. People are always invited to ask for feedback if they want to, but there is no formalised communication process that I am aware of.

The CHAIR: So you would not know. I would not know if I had made a report. I would not actually know what is happening after I had made that report, I would just have to go back to my day job and if I am still interacting, say if I am a school principal or something or other—I know this is not your area. But if I am a school principal and I have made a report, I would have to go back and just deal with the situation on a day-to-day basis without knowing if there was any action being taken to follow up on that report or what the outcomes were.

Hon ROBYN McSWEENEY: If I can just cut in, I was the minister responsible for setting up mandatory reporting—a long time ago it seems now. What should happen is that if a principal does ring into a mandatory reporting line, they take down the details and then straightaway that should go back to the area. So if it was a school principal in Joondalup say, it should go back to the Joondalup DCP and they take over from there and that school principal should be spoken to. That is a requirement that if there is a name taken down, that they are given feedback. Well, it was a few years back; I cannot say what has been happening after the two and a half years. But a lot of people report anonymously, so obviously there is no feedback. But if it is a proper mandatory reporter, they do not report anonymously, they report from who they are; they are a doctor, they are a teacher or whatever. So they really should be getting feedback.

The CHAIR: But you are saying it is not always the case for your doctors and allied health professionals; that they do not always get feedback.

Ms Brennan: It depends on who is reporting and it also depends on probably the process that has been followed through.

The CHAIR: So it depends on who is reporting. I am not asking you to speak on behalf of the mandatory reporting people: Do you have any observations you would like make over what the conditions might be when a person would be gotten back to, if you like? Do you know what is going through the minds of DCP or WAPOL when they choose to feed back to a doctor or not feed back to a doctor?

[9.50 am]

Ms Brennan: No.

The CHAIR: You do not know what the basis is for that decision? I am not saying you should do, I am just asking; it is all right.

Hon ROBYN McSWEENEY: I cannot see how they would not be. They should get feedback and sometimes, probably like every other system, they do not. But if they are doing their job properly, if they are a proper mandatory reporter—like DCP would actually have to talk to that doctor to get more information, they could just take down the information and then leave it, or they should not just take down that information. So, sometimes systems are not working perfectly, but it would be really good to know and perhaps we can work on that further.

The CHAIR: That is what I was really getting at. This is to me an issue that we might try to talk to DCP and WAPOL about—the feedback process. It is interesting that you have been able to confirm for us that the observations that we have been given by other professionals are perhaps correct, that the feedback is not always being provided that might help a professional who has reported to understand what the basis is and what the future is around that person and their child or whatever the situation is.

In your training package I am assuming—this could be wrong, so tell me if I am wrong—there must be some strategies around minimising trauma for the individual, or do you not get involved; you are involved in the reporting, not what happens after reporting? Are there any strategies in your training about minimising the trauma to a child or someone who is the victim or supposed victim?

Ms Brennan: With the face-to-face training that the MRITG group do, that is certainly covered off as a topic and we have health professionals who are trained, obviously, to counsel children who are traumatised or where there is potentially trauma that they are experiencing, so we always encourage professionals to refer back to us if they believe that there is a risk of that.

The CHAIR: That is interesting. One of the things we have heard is the value of the George Jones centre and that model of one-stop shop, which is different from what Blaxell was talking about of course, but in the Parkerville one-stop shop model it seems like a very sensible way of dealing with a very potentially traumatic situation.

Hon ROBYN McSWEENEY: Holistic.

The CHAIR: Yes, holistic. Do you have any observations about that? Have you any experience with the way that model works?

Ms Brennan: Not intimately. I am not sure whether you are aware of the multidisciplinary MDCs that are being set up in Victoria at the moment. There are a couple of sites that are set up as a one-stop shop and so we have been looking at that closely in conjunction with some other agencies in WA, and potentially, I think, there is a plan to have a pilot site where we could trial a model like that.

The CHAIR: Would that do what George Jones is set out to do?

Ms Brennan: Similar, yes.

The CHAIR: But be government run?

Ms Brennan: Yes.

The CHAIR: A cross-agency thing?

Ms Brennan: Yes.

The CHAIR: I know George Jones has been looking at sourcing another centre with private funds and would be looking at the government's support for that as well, so that is interesting. It is good that you think it is a good model.

Hon ROBYN McSWEENEY: So the one in Queensland has interviewing techniques, it has the doctors on site? Do you know much about that?

Ms Brennan: It is in Victoria, not in Queensland.

Hon ROBYN McSWEENEY: Victoria, sorry; I have got Queensland on the brain today!

Ms Brennan: My understanding is that it has a DCPFS or the equivalent—what they are called in Victoria—police, health, so they have a medical practitioner based there who can do the medical assessments, and there is an NGO provider as well providing some of the more therapy-based interventions.

The CHAIR: Which is pretty much what George Jones is doing, so that is really good.

Ms Brennan: The slight difference with the George Jones centre is that there is a medical practitioner who is based there who refers into our child protection unit, but the actual physical investigation of the child is done at our child protection unit at Princess Margaret hospital, not at George Jones.

The CHAIR: I know that the modelling, the way it was rolled out in other countries—in America, for instance—a number of places had chosen to locate its facility, its George Jones centre, at the back of or nearby a hospital so that there was almost a seamless capacity for a child to be involved in the physical or the health aspect of it without necessarily walking through the front doors of hospital. They had either tacked it onto the back or had it in a residential street that adjoined, so there was an easier access for that. Very interesting, Lisa, thank you.

The child protection deals with child sex abuse referrals, what about other types of abuse that are suspected or encountered within the health system? Where would people go for things other than sexual abuse, or do you deal with all child abuse of any nature?

Ms Brennan: That is a good question. Can we take that question on notice?

The CHAIR: Yes, of course.

Ms Brennan: The PMH CPU is not my area of expertise, so we can take that on notice.

Prof. Daly: My understanding is that they would have within their scope all manner of non-accidental injury or abuse, but we will take that on notice to confirm the exact scope for you.

Hon SALLY TALBOT: And neglect as well?

Prof. Daly: Yes.

The CHAIR: We have heard that neglect is the biggest contributor to child abuse, if you like, and the link between mental health, drugs and alcohol in the family is a very close driver around neglect.

Ms Brennan: Certainly with the issues we have in the community, there are probably a few key risk factors. They are drug and alcohol abuse, mental health issues, and family and domestic violence, and once you have got the three together it is almost inevitable that the child is at risk.

Hon ROBYN McSWEENEY: Just on the mandatory reporting, you said there were 104 training sessions. How many people in each training session, do you think, or have you got a figure about how many Western Australians go through that training in the year?

Ms Brennan: So the total number of participants, which include health staff plus other agencies, is 2 359.

Hon ROBYN McSWEENEY: Per year?

Ms Brennan: That was for 2014. As a general trend, I think the numbers have been trending up each year as we have been getting greater coverage, but I do not have the previous histories on me.

Hon SALLY TALBOT: Can you give that to us as a percentage of the workforce, so what percentage of the workforce has had that training in mandatory reporting?

Hon ROBYN McSWEENEY: It would be mandatory. It would be the workforce in doctors, teachers—it would be the five or six.

Hon SALLY TALBOT: To do with the —

Hon ROBYN McSWEENEY: Yes, to do with that.

The education department—are they in great numbers as they are coming through? Are they getting this training or do you have training for, say, doctors on different days or education on different days or is the training just—you would not really know?

Prof. Daly: With respect to the actual numbers, I do not think we will be able to comment on the percentage or the raw numbers of people from each agency, but we do have figures in front of us that speak to the number of non-health participants in training in the 2014 year. As Lisa said earlier, that was 1 061. In a question on notice, we could tell you the number and percentage of people who received training within Health. The online training would lead to a database, so we would be able give you that number on notice, but I am afraid we probably would not be able to tell you the number of personnel from other agencies.

Hon ROBYN McSWEENEY: I thought as much.

Prof. Daly: In terms of the actual running of the sessions, I do not know whether, Lisa, you have any other information around whether they are multi-agency?

Ms Brennan: They are multi-agency, but I could not tell you the composition of each training group.

Hon ROBYN McSWEENEY: No, that is fine.

The CHAIR: Can I just clarify: Are we asking for the proportion of the health workforce that has gone through the training? Is that something else we would like? Yes, so we would like to know whether it is possible: do you anticipate that 100 per cent of the health workforce should go through this training?

[10.00 am]

Ms Brennan: All the mandatory reporters, the doctors and nurses?

The CHAIR: Well, no, that is the different question. Sally, do you want to just be clear about what it is you are asking?

Hon SALLY TALBOT: We talked about how many people have done the mandatory reporting training last year. What I am interested in knowing is what proportion of the department's workforce has done that training?

Ms Brennan: Yes, okay.

The CHAIR: The department's workforce as distinct from the health —

Hon SALLY TALBOT: No other agencies, just —

Ms Brennan: Yes.

The CHAIR: Is that clear?

Prof. Daly: Yes.

The CHAIR: Thanks.

Hon ROBYN McSWEENEY: I know when it first started they were all given training packages. They were given some face-to-face training, but it was done in kit form. I presume it has got a bit more sophisticated since it first came out in 2008–09, which is a good thing.

The CHAIR: Thank you, I will move on.

You talk in your submission about the introduction of mandatory reporting of sexual abuse back in 2009, resulting in the removal of referring a child for a medical assessment from other agencies, processes and practices. I am just not sure what that actually means, so if you could explain that a bit more to us, that would be really great. I will say it again: in your submission you say that the introduction of mandatory reporting of child sexual abuse in January 2009 has resulted in the removal of referring a child for medical assessment from other agency processes and practices. Do you understand the question?

Ms Brennan: Yes, I do understand the question.

The CHAIR: Sorry, could you give us a bit of an explanation over what that meant? It was a bit hard for us to figure it out.

Ms Brennan: My understanding is that when the mandatory reporting was mandated as of January 2009, that, I guess, formalised the process of mandatory reporting through to the department of child protection and now family support services and WA Police. As such, the practice of referring a child for a medical assessment was directed through to those agencies because they became the first port of call for suspected abuse. So, it therefore then is reliant on those two agencies to refer on to us to actually get that medical assessment done. We are now one step removed from the initial referral.

The CHAIR: I understand now.

Hon SALLY TALBOT: I do not quite understand. As far as health is concerned, would not the concern often have been picked up during a medical assessment?

Hon ROBYN McSWEENEY: Not really.

Ms Brennan: It may be, but it may not be.

Hon SALLY TALBOT: So, in the case where it is, presumably there is not a sense in which that medical assessment stops and the child gets directed to the next place—is there? Is that how it works?

Ms Brennan: No. That is not my understanding; my understanding is the medical assessment is completed once it has been commenced. I think what we are probably talking about are those children where you might have a teacher that reports a suspected case, they might report that to WA Police. WA Police do the investigation and then it is up to them. If they believe that a health assessment is required to on-refer to the Department of Health for that health assessment to occur.

The CHAIR: Rather than directly to the Department of Health?

Ms Brennan: Yes.

Hon SALLY TALBOT: But Health can still report, under the mandatory system?

Ms Brennan: Yes. So if, for example, they have come through Princess Margaret Hospital ED and they are covered with bruises that do not make sense to the story that the parents have given, they can obviously do their investigation whilst the child is there. But again, as mandatory reporters, the doctor or the nurse on duty would report through to WA Police and DCPFS, and they would start their investigation process as well, which would include obviously pulling together the information of the health assessment.

Hon SALLY TALBOT: It is not really a replacement of the health assessment, is it? Is it not a parallel system?

Ms Brennan: Yes.

The CHAIR: So, a completely different subject. Can you—either Lisa or Frank—tell us about the Child Safety Directors' Group and how that operates and your involvement in it?

Prof. Daly: Lisa, please.

The CHAIR: Do you sit on it, Lisa?

Ms Brennan: I do sit on it. Frank has attended one meeting, and, to be honest, I have only been acting in the role for 10 months now, so I have attended three meetings. I will tell you what I know.

The CHAIR: Sure, absolutely—understood.

Ms Brennan: I think you can probably pick up what I do not know. The Child Safety Directors' Group is chaired by the director general of DCPFS, Emma White. The membership of it is multi-agency, so it includes a range of agencies from the Department of Housing, the Department of Education, the Department of Health, DCPFS, Premier and Cabinet—I will not list all of them, because I am sure we could give you the terms of reference. The purpose of that group is really, I guess, to pick up on some common themes that are occurring in communities and look at how as different agencies we can come together to try and resolve some of the problems. I think if we work in silos within our individual departments, we often get to a point where things are out of scope for your department, so it is really a group of representation from different agencies who have come together to try and make sure that it is a seamless approach.

The CHAIR: Could you give me maybe a couple of examples of the kind of issues that would be picked up and how they would been worked on?

Ms Brennan: Yes. At the last meeting in particular we were talking about some of the regional areas towards Broome, and picking up on the issue that we have—girls that are under the age of 13 that are getting Implanon implanted. It has set about a cultural issue in the community that there is this nod rod; that all of a sudden we have girls that obviously have contraception that is clearly obvious to men within the community and so they see them as free game, if you like. There is that particular issue. We have also discussed the issue of grooming. Where we have health workers and/or other workers that are going into regional and remote areas, and there may be some underlying child abuse that is going on, and people in the community will pick up that somebody new is in town, and they will kind of groom them and say, "No point in reporting, it has been reported before, it has been investigated before. It is all fine, nothing is going on." They will kind of groom that person. We picked up the issue of grooming and making sure that that is, I guess, covered off as part of the induction before staff are going into those areas. It is often the underlying things in the community that sometimes the trends might change and it is important as agencies that we are addressing those issues in our training and policy.

Prof. Daly: May I add something?

The CHAIR: Absolutely!

Prof. Daly: I only went to one meeting, but I was impressed by the approach by Emma White and the multi-agency committee to look at the issues that may arise, community by community. So, the committee is not taking a one-size-fits-all approach. There is more an approach whereby in a given area, a region such as the Kimberley or the Pilbara or in the south east goldfields, for example, they would look at the issues that might be pertinent there and then come in with a multi-agency approach to that. There may be issues around housing, education, particular issues with cultural mores in an Aboriginal community. They have been taken into account by all agencies that might have an approach there, rather than, as Lisa said, about the silo approach. That particular tailoring to a regional or even to a particular community, I think is one of the key modes of operation for the committee.

Hon ROBYN McSWEENEY: Yes. Because I think child protection has always copped the brunt of it, really, and yet it should be multi-agency, and that is how it should work in every small community. Unfortunately it does not, as you know. But it is good that it is starting.

Hon SALLY TALBOT: So that committee is chaired by the DG?

Ms Brennan: Emma White? Yes.

Hon SALLY TALBOT: Right. Who are the other agencies represented on it?

Prof. Daly: We could provide to you on notice the terms of reference, but from memory, there is probably at least 10 representing broadly, Health, Aboriginal Affairs, Education, police, Housing, the Department of the Premier and Cabinet, disability services, child protection obviously have a number of personnel there, plus a representative from the federal department as well. I have listed, I think, nine off my fingers. There may be one or two others.

The CHAIR: We can check the details, Frank.

Hon SALLY TALBOT: How often does it meet and how long has it been meeting—when was it formed?

Hon ROBYN McSWEENEY: Years ago.

Ms Brennan: I will have to let you know when it was formed—it was a couple of years ago—and we meet every second month.

The CHAIR: Just from your understanding, because you work in the area, is there an NGO equivalent or a link between the directors general of Centrecare and Anglicare and the like who deal with these kind of issues as well? You do not have to know this, I am just wondering if you do.

[10.10 am]

Ms Brennan: No, I do not know.

The CHAIR: I have one final question. Forgive this because it may sound frivolous at first. One of the things that has continued to concern me and comes on and off departments' radars over the years, particularly the radar of police, is the link between abuse in families and abuse of the most vulnerable, not just children. The RSPCA and the police have done some work on the cruelty connection. Is there any discussion between the RSPCA and the chief inspectors who deal with abuse of animals and other abuse that goes on in households? I know it is not specifically about child abuse; it is more about family violence. In most other states of this country, there are committees that involve the RSPCA for the clear connection between the two.

Ms Brennan: I do not know. It sounds like a sensible idea. I do not know is the answer.

The CHAIR: I get that a lot, you know, and I always have done. Every time I raise it, someone says, "Gee, that's a good idea" and then nothing happens.

Ms Brennan: It is a good idea.

The CHAIR: I really do not understand why but there you go.

If the children's commissioner was to develop a greater presence in the regional and remote areas, perhaps working with local organisations for the purpose of education and outreach on this subject, what role would your department play given that health services are generally provided across those areas as well? If she was involved, or he but it is a she at the moment, as the commissioner in delivering training out there in the field in regional and remote areas with local organisations, would you have a role to play in that as well?

Ms Brennan: What sort of training are you talking about? Are you talking about promotion or self-awareness?

The CHAIR: She talks mainly about child-safe organisations. That is really the scope of her involvement at the moment—a concern over how to create a child-safe organisation, recognising grooming and that.

Ms Brennan: I think that would very much be welcomed. I would see that we would work collaboratively with the commissioner to make sure that our training program aligns to but does not duplicate what hers would. The commissioner obviously produced her report that was published a couple of weeks ago around creating child-safe environments, which was a good read. I picked

that up and thought, "This is something that we need to be focusing more on as an agency and building more into our program of work." I would see that we would work collaboratively with the commissioner and make sure that we were not duplicating but we were reinforcing what she was promoting, or he.

Hon SALLY TALBOT: Can I just extend that? What do you think could be done better?

Ms Brennan: Around creating child-safe environments?

Hon SALLY TALBOT: Yes. I am interested in your answer. You have given us a very comprehensive account of what the department does already and it all sounds very thorough and well thought through but what I am hearing from some of your responses is that there is room for improvement. I wonder if you could elaborate on some of those areas where you think things could be improved.

Ms Brennan: I think there are probably two components. The first part is obviously the people and then there is the physical building itself. If we focus on the people, I think that as an organisation, we are required to deliver training to the mandatory reporters, who are the doctors and the nurses. I believe that we probably should be extending that training more broadly to allied health professionals and other staff members. I think anybody who comes into contact with children on a day-to-day basis should —

Hon SALLY TALBOT: So you do not deliver that training to any of those ancillaries at the moment?

Ms Brennan: We do upon request but we are not required to as part of the legislation. I can speak for my service, for example, and say that within my child development service, we have provided training to them about not just potential sexual abuse cases but any form of abuse. We also provide training to all our nurses around potential neglect but it is not mandated. If we have new staff members who come in, let us just say in December and we delivered the training in June, we potentially are not picking them up straightaway. I think we could do better at more broadly raising the awareness of neglect and child abuse across a greater spectrum of health professionals.

The CHAIR: When you say "nurses", are agency nurses included in this training as well or is that outside your remit?

Ms Brennan: No, they are included as well.

The CHAIR: Is there no mandatory reason for them to be given the training? You said it is not mandated.

Ms Brennan: It is mandated for the doctors and nurses. The allied health professionals are not mandated.

The CHAIR: Are agency nurses still considered part of the department's remit?

Ms Brennan: Yes.

Hon SALLY TALBOT: Perhaps you could have an addition to that earlier question on notice that you talked about—how many people have received the training. Can you include some numbers relating to allied health professionals who requested the training and have it delivered to them?

Ms Brennan: Yes.

The CHAIR: There are so many players in this area, it gets a bit confusing. Could you give us a bit of a rundown on the Statewide Protection of Children Coordination Unit?

Ms Brennan: I will tell you what I know. The Statewide Protection of Children Coordination Unit is what we call the SPOCC unit, so I will use that term and it will save me saying it each time. They sit within my service, which is the child and adolescent community health service, but they work very closely with the child protection unit at Princess Margaret Hospital as well as the

department for child protection and WA Police. Their role is primarily to coordinate the training but also, I guess, from a policy perspective to make sure that, for example, children in care receive a health assessment within the first 30 days of being received into care. They have a policy component as well in terms of children who are already in care. We also collect data on making sure that those health assessments occur, which that unit collects data on.

Hon SALLY TALBOT: Who is on that group?

Ms Brennan: Within that unit, the manager is Sue Hudd.

Hon SALLY TALBOT: So this is a unit of the Department of Health?

Ms Brennan: Yes.

Hon SALLY TALBOT: How many people work in that unit?

Ms Brennan: I can take that as a question on notice. I have a couple of people—one who has left and I have a position that has not been filled. I will provide that back to you.

The CHAIR: I have a different question. From both of your experiences in this area, would you like to make any comments about what you see are the obstacles or challenges that your department faces in your role in preventing child abuse? Is there a role that you see you have in, first of all, preventing child abuse? It is arguable that you are really at the front end—it has happened, it is happening, so it is a fact. You do not have a role in preventing it so much but in spotting it when it is happening. Do you have any ideas about those challenges? Does Health have any involvement at all in the prevention end of child abuse?

Prof. Daly: Excuse me because I have very little operational experience in this area and I have been in the Child and Adolescent Health Service for only a short period. I think you have raised a valid issue in that in many ways Health has a role in picking up and getting involved in cases that have already occurred rather than being in a preventive role. If Health was to have a future role, it should be in greater collaboration across many agencies and perhaps participating in not only collaboration but also research in understanding the underlying psychosocial factors that may be involved in the epidemiology of this problem. As I said, I was very impressed with the safety committee in the fact that agencies as diverse as Aboriginal Affairs, Education, Housing and police are all having conversations around how they can each have a view around the factors that are operating within a small community. It is getting into communities, speaking in a language that people can understand and understanding the underlying social issues that are associated with these conditions that will lead in future to better understanding and better prevention. I do not think necessarily that one single agency or profession can really own that. I think it has got to be a social approach that is owned by many.

[10.20 am]

Hon ROBYN McSWEENEY: It does start with your child health, though, as a preventive.

Prof. Daly: Yes.

Hon ROBYN McSWEENEY: Just being a new grandma, I have actually seen the work that the child health nurses do under what I would say were adverse building conditions. But they actually do point the young mums in the right direction. It is really good to see.

Ms Brennan: Yes. In terms of health promotion, we obviously do talk to new mothers about the risk of any form of drug and alcohol abuse and also we cover off issues around mental health, in particular postnatal depression, and we will give them information about where they can seek services or advice or how they can access information. But I think that the question you are trying to address is: when we know that there are these multiple risk factors, what are we doing as a community to really promote a healthy environment and to prevent child abuse cases? I think that, as Frank has articulated, it probably needs to be more of a multi-agency evidence-based approach.

The CHAIR: If we flip now to the cases of abuse being reported and the justice system becoming involved, do you guys have a role in tracking or supporting a child, or a family even, through the justice process as that gets rolled out? I am not saying you should do, but do you have one at the moment?

Ms Brennan: I can talk to this and I guess what I would probably say is that it is very much on a case-by-case basis.

The CHAIR: How interesting.

Ms Brennan: I can give the example of if there is a child that is coming to Princess Margaret with ongoing health issues, then obviously as part of the health team providing support to that family, they would be providing holistic care to that child throughout the child's journey. However, if there is no natural point of intervention from a health point of view, then we may not potentially be providing that support through the child's journey. Does that make sense?

The CHAIR: I understand. If the child is in your system and is identified within your system, then you would give some support and advice to the family and the child on that journey.

Ms Brennan: Yes. But if they had been reported in but there is no underlying health issue that needs to be addressed, then as a service provider, we potentially may not see the child again until there is an identified health issue and they get referred back to us.

The CHAIR: I have a final question; I will just warn my colleagues that this is my final question. We have received evidence that there is a lack in continuity of support for children and young people and their families who go through the process of reporting abuse. What is your view about this given your experience in dealing with cases that come into your purview? Do you have an observation about the overall lack or not of continuity in that support for a child and a family? Have you seen that happen? Have you any comments about that?

Hon ROBYN McSWEENEY: Very complex, that one.

The CHAIR: There is no right or wrong answer; just tell me what you think.

Ms Brennan: I am just sitting here trying to think about it from the family's perspective and I think it would be fair to say that from their perspective they have an interaction with several different agencies. It might start off with the Department of Health, they may then be referred into the department for child protection and they may have contact with WA Police. I think from a family's perspective, what is often missing is that continuity—one person to provide central support to feed back, to communicate. They probably have different people communicating back to them at different points in time and it probably feels quite disjointed.

The CHAIR: It is interesting. I know we are just finishing, but we looked at other models in England and Scotland, for instance, where they have this named person concept in legislation, which is very interesting. It is probably a stretch too far for Western Australia to be considering, but we think it is a very interesting initiative.

Ms Brennan: Certainly from a health perspective, we know that coordination of care—this is a slightly different tangent. When you have patients that have multiple medical issues and need to see, perhaps, disability services, the Department of Health and other agencies, having somebody to coordinate that care and be that central conduit is very important. I think it is a good model that could apply, but I think, Lisa, you might be right in that it is interesting. Whether or not we could implement it in WA, I am not sure.

The CHAIR: It is interesting.

Hon ROBYN McSWEENEY: Child protection has StrongFamilies but they are for the really worst cases that need multiple help from multiple agencies. That is a sort of liaison; there is one person there. It is not really a bad idea. It could be set up to go across Health and police and

child protection quite easily. For the worse cases, you would actually have one central coordinating unit.

The CHAIR: It is an interesting model.

Ms Brennan: We do have StrongFamilies, and obviously WA Health is one of the agencies that is a member. I think that perhaps, Lisa, what you are also asking is what about for all of those families that are not quite at that stage that they are suitable for StrongFamilies?

The CHAIR: Yes; outside of StrongFamilies.

Ms Brennan: Yes. What about all of the rest? That is how I understood your question.

The CHAIR: That is correct—the broader scope. Just before I let you off the hook, in Health's experience in child protection, would you just talk a little bit that how confident you are in the current avenues that are available for disclosure of abuse? From Health's perspective, do think that there is enough? Do you think they are working in terms of the avenues that a child has? Take for instance Katanning—30 years ago but until quite recently—or take any one of the other cases that we are likely to see or have seen recently around this. Do you think that for children in care and out of care, for children in the community, the children who are not on the radar of anybody—no medical professional, anyone—do you think that there are enough avenues for disclosure for that child who is not on anyone's radar? They are simply sent to a boarding school in the country. Do you think that child has a good avenue for disclosing abuse nowadays? I know it is only your opinion, but it is your department.

Ms Brennan: I think—this is just my opinion —

The CHAIR: This is not Health's policy perspective.

Ms Brennan: It is not Health's policy perspective. I think the avenues through WA Police and also the department of child protection are sometimes seen as perhaps a bit confronting and a bit scary, particularly for young people and I guess that is why Health has a really important role to play because doctors and nurses are seen as people they can trust and talk to and I think we are a very good avenue. Is there enough? I think there is enough evidence if you look at the historical cases to say that, again, perhaps we could be doing more in this area. In my opinion, there should be no case that goes unidentified but we are still picking up cases that have been going on for a number of years before the child has been identified as being abused.

The CHAIR: I think we share your views that there should be none of this but there is always going to be because we cannot have a failsafe system. You have to have the best system that you possibly can but it is never going to catch everybody. People are really clever. Is there anything that you want to finally add or any final comments that you want to make? I hope we have not been too arduous.

Hon SALLY TALBOT: I have got a couple more questions if you have time?

The CHAIR: Have you got time for a couple more questions?

Prof. Daly: Sure; of course.

Hon SALLY TALBOT: They are really just recap questions. The training that you roll out has obviously evolved over the five or six years since it has been introduced. Do you do any monitoring of its effectiveness?

[10.30 am]

Ms Brennan: We obviously do evaluations of the training, so we ask staff, as part of the evaluation process, whether we have met their needs. But I think if you are talking about effectiveness you are probably talking about outcomes—are we able to change outcomes? I am not sure that we do—if I could take that as a question on notice, that would be good.

Hon SALLY TALBOT: Yes, if you can give us any idea about how you might evaluate outcomes, it would be good. My final question was just to ask you about your day-to-day interaction with the commissioner and the commissioner's office. Do you have regular contact?

Ms Brennan: We have contact in the context of, obviously when there are key events that the commissioner has organised—it might be a resident thinker, for example. I attended an event last week where we had a professional who had come over from Italy, so in the context —

Hon SALLY TALBOT: So you are on the guest list?

Ms Brennan: On the guest list, so in the context of those things obviously I attend those events, and the commissioner, as soon as there is a new report or a study or a finding that she feels is worthy to share with the key agencies, that is just submitted to us. I guess there is a two-way exchange and when we feel that there are issues that perhaps should be directed to the commissioner, then we will do that, but there is not a formalised meeting agenda, and there is not regular contact.

Hon SALLY TALBOT: What about the commissioner's ambassadors? Do you have anything to do with them?

Ms Brennan: I do not personally, no.

Prof. Daly: The commissioner and I have met on a personal one-to-one basis just to introduce ourselves and discuss general issues, and I believe we have set up a system just to meet personally, without agenda, periodically just to catch up.

Hon SALLY TALBOT: So that is just an informal arrangement is it?

Prof. Daly: That is right.

Hon ROBYN McSWEENEY: So the government does not put her on the Child Safety Directors' Group, do they? She does not come to those meetings.

Ms Brennan: Not that I am aware of.

Prof. Daly: Not that I am aware of.

The CHAIR: I will read my closing statement. Thank you for your evidence. The principal research officer—this would be Vanessa—may write to you in the future about additional matters the committee wishes to clarify as a result of the hearing. A transcript will be forwarded to you for correction of minor errors. That needs to be returned within 10 days of the date on the letter attached to the transcript. If the transcript is not returned, it will be deemed to be correct. New material cannot be added or the sense of your evidence altered. If you wish to provide additional information or elaborate, please do so in a supplementary submission. We would be happy to receive that. Thank you so much. You were really, really helpful and it is very valuable to have Health here.

Hearing concluded at 10.32 am

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